CONSENT FOR DERMAL FILLER INJECTIONS

I authorize_____ to perform temporary, semi- permanent, or permanent dermal filler injections on me and understand that this procedure is purely elective.

I understand and agree that during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those explained. I request and authorize Weeks Family Medicine personnel to use their professional judgment for my care and consent to the use of any anesthesia that WFM personnel may deem appropriate or necessary.

I understand that serious complications are rare, but possible and that this treatment may involve risks and complications have been known to follow these treatments even when performed with the utmost care, judgment and skill. Complications may include bleeding, bruising, pain, swelling, scarring, infection, allergic reactions, altered sensation, injury to the skin or deeper tissues resulting in cosmetic defects, and failure to achieve the desired result. I understand that rare complications such as vascular occlusion or embolus can lead to scarring, nerve and blood vessel damage, and facial skin and/or muscle loss. In rare cases, unusual reactions may occur that cannot be predicted.
I understand that some areas of treatment are considered “Off Label”. These have been discussed with me and I consent to treatment.
I acknowledge that no guarantees have been made to me regarding results, complications, final outcome, or unfavorable results. I accept the risk in hope of obtaining the desired beneficial result of these treatments.
I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publication, promotional and sales purposes. These photographs may be used and displayed publicly without my permission. I understand that I will not be entitled to any compensation as a result of the use of these images.

I certify that I have read and understand this form. Pre- and post-treatment instructions have been discussed with me. This procedure, and its specific benefits and risks, and alternatives have been explained to my satisfaction. I understand the potential risks and complications involved and have decided to proceed after considering the possibility of known and unknown risks. I understand that not adhering to the post-care instructions provided will increase my chances of complications. I have had the opportunity to ask questions and have had all of my questions answered to my satisfaction. I freely consent and authorize the proposed treatments. I understand that payment is required at the time of services. By signing this consent, I certify that I am not pregnant or breastfeeding.

_____

Patient Signature Date

_____

Witness Signature Date